Virtual Task Force Meeting - June 18, 2020

Indiana State

Suzanne Crouch, Lt. Governor

>>SUZANNE CROUCH, LT. GOV.: Wonderful. By the time we get all this technology down, it will be time to start meeting in person. I want to thank Kylee Hope and her entire team for all their work and effort to make today a reality. And we appreciate it so much. So with that, I'll open the June 18th, 2020, intellectual and developmental disability task force meeting. And what we will start with is the introduction of task force members. So I will call your name, and if you are on the call, or on the -- whatever we're doing, web X, or zoom, please just say that you're here or that you're present so that we will know that you're participating.

Kim Opsahl? Thank you Kim. And we have Anam Abidi? And who is representing?

>>SPEAKER: That's Brian Gilbert, is here.

>>SUZANNE CROUCH, LT. GOV.: Thank you. Is Eric Hester here? I'm sorry. Eric Heeter. I'm sorry. I apologize. Eric.

>>SPEAKER: This is Jay C, with DMHA, I am director now. List hasn't been updated.

>>SUZANNE CROUCH, LT. GOV.: Is Christine Dahlberg here?

>>CHRISTINE DAHLBERT: I am here.

>>SUZANNE CROUCH, LT. GOV.: Great. Thank you Christine. Nancy Holsapple?

>>NANCY HOLSAPPLE: I am present. Thank you.

>>SUZANNE CROUCH, LT. GOV.: Wonderful. Thank you. Jan Kulik? All right. Elizabeth Peyton?

>>ELIZABETH PEYTON: I am here.

>>SUZANNE CROUCH, LT. GOV.: Thank you Elizabeth. David Reed?

>>SPEAKER: Austin is here in place of Reed.

>>SUZANNE CROUCH, LT. GOV.: Kim Dobson?

>>SPEAKER: I am here.

>>SUZANNE CROUCH, LT. GOV.: Thank you Kim. John Barth?

>>JOHN BARTH: I am present.

>>SUZANNE CROUCH, LT. GOV.: Thank you John. Welcome.

>>JOHN BARTH: Thank you.

>>SUZANNE CROUCH, LT. GOV.: Kathleen McAllen?

>>KATHLEEN MCALLEN: I am here.

>>SUZANNE CROUCH, LT. GOV.: Thank you Kathleen. Joe Langerak?

>>JOE LANGERAK: Present, ma'am.

>>SUZANNE CROUCH, LT. GOV.: Shawn Fulton?

>>SHAWN FULTON: I am here.

>>SUZANNE CROUCH, LT. GOV.: Thank you Shawn. Daniel Maze? Jason Meyer?

>>JASON MEYER: Good morning. I'm here.

>>SUZANNE CROUCH, LT. GOV.: Thank you Jason. Jonathan Burlison?

>>JONATHAN BURLISON: Present.

>>SUZANNE CROUCH, LT. GOV.: Thank you Jonathan. I know Kylee Hope is here. And I am here. I heard senator Becker earlier. Welcome Venita.

>>VANETA BECKER: Thank you.

>>SUZANNE CROUCH, LT. GOV.: Is senator mountain with us? Representative Klear?

>>SPEAKER: Good morning.

>>SUZANNE CROUCH, LT. GOV.: Good morning Ned.

>>SUZANNE CROUCH, LT. GOV.: And representative Hamilton?

>>CAREY HAMILTON: Good morning. Glad to be here.

>>SUZANNE CROUCH, LT. GOV.: Good morning. All right. With that, our next item on our agenda is review and approval of the minutes of January 7, 2020. We took that action at our meeting previous to today's meeting. So while those minutes are approved for board members who were not present, do

you have any changes or corrections or additions that we need to reflect?

If not, those minutes stand as approved. So, our next item on our agenda is our continued statewide crisis assistance program presentation.

And what I would like to do is to introduce right now the presenters, and then we will start with Doug Bebe, and Doug, you will make your first presentation, and you will hand it off to Bob Coles from Meridian health services, and then Bob, you will hand it off to Jim W from milestone clinical and health resources. So I will introduce each speaker. I'll do that right now but then you all need to hand it off to the next presenter.

So the presentation on the continued statewide crisis assistance program will be by benchmark services Doug Bebe president and CEO, Bob Coles, and -- clinical health and resources Stone Belt will be Jim Wiltz Ph.D., HSPP, NADD director. So with that, Jim, we'll welcome you.

>>DOUG BEBE: Good morning. Thank you. And I would like to thank the Lieutenant Governor and members of the commission for addressing this. Benchmark has been in business since 1960, if you could go to the next slide please. I want to give you a brief overview of who we are, and what we work with. We have a broad spectrum of services. We have been working in

crisis since 2007. We have been providing employment services since 1963, and with 3500 employees last year we served about 20,000 people. What I really want to emphasize is that Indiana IDD crisis program started in 2007 we ended up doing 1900 total responses during the years we did that crisis program. When that was completed, we started doing IDD service in Georgia, where we have done about 3200 responses, purely for people with intellectual disability. We have also been doing behavioral health and then in 2019 the state combined the IDD and behavioral health response and added an Autism component. So they had blended response teams and we're still doing hundreds and hundreds of responses per month in Georgia. And then in the last year, we worked with the state of Alabama on designing a new crisis system for their state. They have a challenge much like we do with a mix of urban and rural settings, and they're currently looking at the a community collaborative approach where they're doing something like this and bringing in share holders from various domains to speak to how crisis can impact the system, how can it help the police, how can it help the emergency rooms. Next slide please.

What we do in Indiana, the system was set up very well, and Dr. Wiltz who will be speaking later is one of our collisions and can speak to the components clearly. We had a triage by phone and typically responded within 24 hours. In Georgia, the

demand since the beginning that we have teams that respond within 20 minutes. We have strategies in different states where we have fewer teams in Indiana but a longer response time and a longer follow-up, and I'll go into that in maintain. We go into a crisis situation, reduce the risk that was present, provide stabilization as much as possible. When people do need out of home services, Indiana system lease beds in psychiatric hospitals for short stays which was a nice deal for everybody involved because the psychiatric hospitals knew that we were going to be getting the personnel and not just put someone in bed and leave them there for weeks at a time.

And it did provide psychiatric, seven homes for adults with IDD and two homes for kids who go into crisis in homes situation that are too dangerous or unstable for them to stay there. And the theory is to then move it that person back into the community and the moving out part has been difficult to be frank. Other ideas, prevention strategies, try to eliminate reoccurrence and recidivism. Indiana program in particular once we intervene with someone, we were to follow that person for up to 11 months, and when the goal is zero recidivism into the crisis system. Georgia is more the get the intervention done, hand them off to Indiana services and that's the role of the crisis team. So it's shorter term intervention with some warm hand-offs to other services. But the theory is let's use the

emergency response, using a crisis team instead of the police. So one of the things we saw in Georgia as the program went on, was the first year 50 percent of our services were in the emergency department, now it's only about 10. So we have unclogged a lot of emergency departments which were ill suited for many of the crisis that were there. Police often now wait for us, we partner with the sheriff's association so they don't have to have their officers tied up processing these things and trying to figure out where they go and letting us come in and intervene as well. And we also have become, I would say good friends with the courts, because we can avoid a lot of the hearings that come with the arrests. So unclogging big pieces of the system for the larger system, but we have also given people, I think, a better intervention, when they're in crisis, and give them some stabilization supports, wrap-around services, make sure that we keep people in the community wherever possible, and it's an interesting dynamic when the person you're working with is also homeless. But, we have been working through it,and over the course of the years, we have done almost 70,000 interventions now on a variety of different settings. So, next slide please.

In Indiana, the structure was very heavily clinically oriented, and the idea was that we would have our teams do wrap-around services in the person's place of residence or wherever they

lived, we would go there, supply the services, maybe do enhanced training, we did a ton of community outreach and training. Georgia, likewise, we would go in and we can do an onsite stabilization if the person can stay in the home with additional supports, we actually have follow along services that would work in that person's home, and if they have to go out into a crisis home we would have staff. But it's a mix of licensed clinical social workers, licensed behavioral clinicians and highly trained DSPs, and then the homes that we use, we have LPNs as the managers because we have a lot of stabilization issues. And in the last year, they combined all this into one, so combined our two clinical teams under the current structure, two people have to respond to any call, and we still have an hour limit, and what we are able to do as they added Autism services, and that population started having a lot more behavioral health challenges, 80 percent of the team was cross-trained. So we have always have Autism expertise as well as behavioral health and IDD expertise on the team so as no matter what the response calls for, we have people who have the expertise. We also use peer support specialists quite a bit under behavioral health crisis, and it's been a nice support because I think that's often how people see they have an ally in this situation, it's not just not more clinicians telling them what to do. So it's been a very successful program that has been continued. It was

spurred on by DOJ. Those sanctions are being lifted, but they're keeping the program intact. Next slide please. And just to give you an idea of how the two models work differently, they both start with a call center, in the Indiana case, we had our own call centers we notified the crisis team they identified the assessment and decided what to do and once that determination was made the big difference between the two models is that Indiana required a long-term follow up to ensure the person stayed stabilized in the community, and I think it was highly successful in that way and the other piece that was nice in this is that we worked closely with the state the whole time so any time we did an intervention, the result of the intervention, follow up services, even if there was an arrest or a hospitalization avoided or shortened the state signed off on those clinical outcomes of the program so that everyone agreed about what kind of successes we had. In George a as I said it's a much more shorter term, we had acute crisis -- you have to be there within 60 minutes within acute crisis and stabilize the situation and activate follow ups. And the issue we have in the short-term interventions in Georgia has been that once you intervened and handed the person off to services that's considered a successful intervention whereas in Indiana there is a long follow-up period that says let's keep the person stabilized, boost community supports, and they -- sorry. Lost

my screen for a second -- we would go ahead and discharge them but continue we can see the same person in crisis services sometimes five or six times in a year so the long-term stabilization component in Indiana was not present in the Georgia program. So that's a brief summary, and I'll be glad to take questions if there are any, and otherwise I'll hand it off to you Bob.

>>BOB COLES: Hello. Can you hear me?

Okay. Thank you very much.

>>SPEAKER: Yes, Bob we can hear you.

>>BOB COLES: My name is Bob Coles Vice President of Meridian health services. Meridian services is an integrated health care service. We are a federally qualified health center and licensed by DHA for mental health and addiction services and we have been providing services for more than 45 years. Last year, in 2019, we served over 40,000 patients. We operate 47 facilities in the state. We served over 18,000 children, and we provided over 526,000 outpatient visits.

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So in 2007, Meridian contracted with the state of Indiana as one of the providers for crisis management. During the time of that service, which lasted until 2010, statewide, there were about 925 patients that received crisis services. For the services that we were providing, there were 230 emergency room visits

prevented, there were 305 psychiatric hospitalizations prevented, 35 hospitalizations prevented, 68 incarcerations prevented, 296 police runs prevented, and 17 state hospital placements were prevented.

And that saved the state about $7 million by preventing those incidences.

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So the services that were provided during that crisis contract included 15 full time crisis staff that were funded through the state contract, and these staff provided 24-hour crisis line, in-home supports of which they responded within 24 hours to a crisis, a temporary out of state stabilization services, which utilized subacute facilities, and other resources actually from other DD providers. And then there was a follow along and a period for managing to help keep, you know, the person stabilized, and if there was a reoccurrence then crisis stepped back in again to provide whatever would have been needed.

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So since 2007 through 2010, Meridian's Connections program, which is the specialized program that Meridian has that serves the dual diagnosis population, and that would be people with an intellectual disability and mental illness, that that specialized program has served over 6,000 patients. Currently, we have 16 -- about 16 hundred people in our Connections program

that we're providing services, and about a third of those are children. Services that are included, provided through the Connections program, includes individual family therapy, group activities, skill building services, psychiatric services, primary care, and 24-hour crisis line.

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So since 2010, Meridian's commitment to providing services has continued to provide crisis services.

We developed Connections 15 years ago, and since 2010, we felt that it was important to continue a crisis service for the people who were patients in our treatment programs. So our crisis service consists of the crisis line to help deescalate, you know, prove that support system. We also have volunteer staff that are on-call for crisis services and if necessary, they will go to the person where the crisis is at, and then whatever is needed to help stabilize that situation, they will do that.

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So crisis services, this crisis service that we have continued to provide, in 2019, has prevented 39 hospitalizations, 44 police involvements, 36 emergency room visits or hospital admissions. It has prevented 53 people from harming themselves or others, and it has prevented 25 placement disruptions where the person would have to be taken out of their home environment

and has helped people be able to increase their ability to use skill building to help themselves with coping with stressful situations.

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We're going to be looking to the future, and we believe that we have resources in Indiana that would be able to provide the crisis management that would be needed. Also, we feel that in looking at the three presenters here, that are presenting today, that between the three, we have a lot of resources that could be coordinated to work together to make this a very effective program.

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So the conformance for a statewide crisis program that we are proposing would include the 24-hour telephone hotline, it would include in-home service as determined clinically necessary, and that would include having to go to the site, wherever that would be that the crisis was occurring for onsite stabilization. It would include risk reduction and stabilization so that following the initial crisis episode, each person would receive an average of eight hours per week of follow up services for the first month, and four hours per week the second month. And then services would continue as needed on an outpatient basis referred to community resources, or to Meridian's Connections programs, as whatever might be needed for that individual.

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So program components also would include temporary out of home placements, and what we're proposing is that we would get funding to operate three temporary homes for adults and that we would then contract with other -- that we would contract with other community resources in the case of juvenile and children that we would be able to accommodate, if needed, and out of home temporary placement. We also have the telemedicine capacity and coverage currently Meridian operates a psychiatry hub out of our Indianapolis office and we have, at the moment, seven full time psychiatric providers that are providing services throughout the state. Meridian is currently providing services in 35 counties throughout the state, so this type of service is very important, which gives people access to psychiatric services that they wouldn't have before.

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So what we are projecting for a cost of this, for, you know, state funding assistance with, is that we're looking to provide this service for eight regions, the eight regions with DDRS and five crisis staff per region for a total of 40 staff that would cover these regions, also there would be 25 staff that would staff the three homes that we would propose to implement. And then we would use psychiatric time and nurse time for those situations where we needed on psychiatric or, you know, medical

services. So we're looking forward to being able to fund that staffing of five and a half million dollars, we're estimating, would be needed for that, housing which would include the temporary homes that we would operate and if necessary other out of home placements for stabilizations that would be more acute. 1.1 million training with evidence based practices for the staff we're estimating a cost of about 50,000. And other types of services which would be psychological testing, crisis line, and those types of things, about 350,000, so for a total of $7 million that we would want to get assistance from the state to help fund and in doing this, being able to do this for this amount, Meridian being a mental health center, has access to the MRO funding source through meditate. And so for those people that would have Medicaid, and that we would be able to provide a lot of services that would be done with these crisis stabilizations, would -- could be funded through the MRO fund source, and then in so being allowed to do that would then be this -- these other funding from the state to help support the whole crisis services that would be needed to be done.
So I believe that we are -- I believe that we would be able to do this. We're looking at a client capacity through the state of 950 people based off of the data the last time we did the crisis service.

So with that, I will then pass it on to Jim Wiltz from Stone Belt.

>>JIM WILTZ: Okay. Can you hear me?

>>SPEAKER: Jim if you could just speak a little louder for us.

>>JIM WILTZ: Okay. Can you hear me now?

>>SPEAKER: Yes, sir.

>>JIM WILTZ: All right. I'm going to wait until this slide gets put up.

There we go.

All right. Thank you Lieutenant Governor Crouch and the rest of the task force for the opportunity to present today's crisis support. As Doug from benchmark and Bob from Meridian have shown Indiana providers know how to design and implement effective crisis services. Please advance the slide.

Along with Bob and Doug, I have been asked to present today based on my experience which includes having directed the southern region crisis team with benchmark at the time from 2007 to 2010 I have designed crisis support inside Indiana and published crisis at a number of national and regional crisis on these designs much please advance the slide.

My current role is the clinical director of milestone which is part of the southern belt in Indiana and we provide services to

about a thousand people with dual diagnosis every year. This includes outpatient psychiatry, outpatient therapy, we have behavior support services and skilled development partnership with center stone and that's MRO funding similar to what Bob was referring to earlier. Please advance the slide. So this is just kind of looking at where we are in Indiana now, as we have already discussed, we had a crisis service that was nationally recognized from 2007 to 2010. In 2014 the university of New Hampshire Shire performed a gap analysis that studied the same issues that the task force was looking at focusing on moonlit supports and gaps in crisis support. Here we are now within this commission and looking at possible future designs for people with intellectual and developmental disabilities. Please advance the slide.

So this slide is kind of intentionally left blank because this's what's left of the crisis program. I know that Meridian services does some things through MRO services those are limited geographically and would be limited to only Medicaid recipients really wouldn't be able to help a lot of families and family supports waiver and it's very regional. But what we had in the state contract, there is nothing left. So please advance the slide. Then in 2014, the university of New Hampshire Shire came and performed this gap analysis study it was a very well designed study many stakeholder participants several focus

groups interviews, are did a really good job compiled data on some of the gaps and services from 2014. I would also like to point out that those gaps, you would see similar reflection of gaps today.

Please advance the slide. So here, and I know that the picture is kind of small, but I think if you click the advance one more time, you will kind of get a little circle on the last, those bottom five items. There you go. And those represent different crisis supports that were either available or not available, and those numbers actually represent the actual availability for those for people in Indiana with -- who would need them. Highest number there is 25 percent. So over 75 percent of the population is without any crisis supports. Please advance the slide. So the new initiatives based on the gap analysis. This slide is also left intentionally blank because we didn't really do anything with the study that showed these very wide gaps in service availability. Please advance the slide.

So here we are with the task force recommendations. Again, I know that the print is pretty small. This is actually a cut and paste straight from the report that you all wrote. And I draw your attention to the top three, and I know Bob highlighted this pretty well, as did Doug, please advance the slide.

Look familiar. It this is what we did in 2007 to 2010 provided 24-hour hotline support quick turn around we had a 24-hour

requirement for in-home services if they were needed but usually we didn't wait 24 hours. It was usually something we would figure out what the time frame was which was usually within a few hours and it allowed us to work with multiple crisis at the time. Temporary out of home placement, that's psychiatric hospitalization, there are several ways to do this Meridian service desert it a little differently than the way that benchmark did it but either way, you know, we were trying to prevent these, but if needed, it was a very needed service. Please advance the slide.

One thing they find very encouraging based on the report and the recommendations that this task force, the recommendations was that there was some improvements on crisis. So for example, we didn't have -- we did a little bit of telemedicine, just a tiny bit because our psychiatrists lived in Indianapolis and we had occasional supports for Evansville but it was very intermittent and the technology has advanced so much that this is a real -- this is a way that we can really provide additional supports for families. A good example is, let's say that you have a psychiatrist in one area and you have a behavior clinician go to a home, they can actually set up at a home where they have a face-to-face meeting, and let's say mom and dad lived 25 miles away, the mom and dad could just log in on either a phone or their computer. They wouldn't necessarily have to

take a day off work, there wouldn't be transportation issues. So there are just so many ways that, particularly for a crisis service, that telemedicine is a resume benefit. Please advance the slide.

Other task force improvement is risk management. And if you think about crisis services, most of the time what happens is something bad occurs. You know, maybe there is an aggressive incident, and the crisis service then is very reactive. We get a call, we go out we help. And that's great. It's a very important component. But one thing we can also do is we can put preventative measures in place and this is part of the recommendations the task force has and I thought it was a big improvement it allows for the that preventative part that not all reactive crisis services are able to do very well. Please advance the slide.

The third major improvement from my perspective, would be having direct support professionals on the team. It's great to have clinicians, that's all we kind of had last time around. And there were times that BC, behavior clinician would go into a home, make an assessment and start issuing recommendations and then leave. Sometimes, especially if this is a family home, a parent with a young child who has been really problematic it's helpful to at least have the resource of a DSP, a direct support

professional, who is go into the home, work directly with the family, possibly provide training. One training could be deescalation type training, one training could be if you have to hold your kid in a restraint, here is a safe way to do it. That is such a needed aspect to the crisis program. I thought it was a wonderful improvement that the task force recommended. Please advance the slide.

So I wanted to just go a little bit back to basis and Bob covered some of the outcomes pretty well. I'm going to cover it from a little bit different perspective, and I also, on this slide, these next slides, offer kind of a resource to look at what do crisis -- what does crisis look like. What does a call look like. So please advance the slide.

Advance the slide again.

You know, this is really -- this kind of encapsulates what a lot of people feel like, when something happens and they have a crisis in their home. It can be scary. You're seeing stuff that you don't -- you don't feel safe, and so having a resource, it's a tremendous help to families to know that there is somebody to call. Please advance the slide.

Thanks. So one of the things that crisis supports can do is you respond quickly. You can actually minimize danger. I think that some of the things that are really, really important is you can prevent hospitalization. Or prevent -- so many different

times that, when I was working crisis before, I would get on the phone and I would talk to a police officer and they would say okay you have a place for this person to go, but I'm not going to take him to jail. That's a palpable outcome that really benefits those folks. Because you know, incarceration can lead to a lot of bad problems including loss of placement, you know, provider can have difficulty continuing to provide support, if that client is continually having problems and there is no solution.

So I included a few examples and I'll go over them briefly. This is a typical example. Although every case is unique is where somebody is having a behavioral issue and other people feel like it's dangerous, you get a crisis call they want very bad for you to get that person in a hospital. You know, take them away. This is scary. So what we try to do, this is where the in-home supports were very helpful, if somebody wanted a hospitalization, we would send a clinician in there and start working on it. There were times we didn't have at home placement. That's a big part of the crisis, but it's to prevent hospitalization and incarceration and to prevent the costly and disruptive placement change, which can services. Advance the slide. These are two more examples. One I mention briefly. You know, sometimes somebody was in jail, and we could arrange transportation to an out of home place, which was less

restrictive it's treatment rather than incarceration. We also very often would get a call from an overwhelmed parent saying I love my kid but this is dangerous and things are going badly or he just hit his little sister. Things like that. And trying to help that parent overcome these problems can be a tremendous resource to the community. Please advance the slide.

Another thing I want to do is go over a few easy to read charts. This shows the age range of the people who are in our crisis services. I remember I was there when we started the whole thing in 2007, and our -- we figured that this was going to be an adults only thing. That we would just only occasionally have kids and it turned out that 25 percent of our clients were kids. And that was a surprise. So you can kind of see, it is mostly younger people. Young adults. A lot of people between 6 and 20. But we could reasonably expect to see a similar chart if we were to do this again. Advance the slide.

This is a little bit harder to read with the three bars and three colors and the three years that we were doing services. One on the far left is phone only, the middle is in-home, and then the far right is out of home placement. Yellow bar on the far right represents our final year of service. We dropped the percent of out of home placements to ten percent. And that was by doing more services in the home and that was the kind of -- this chart really shows what we want to accomplish. Every

now and then somebody calls and says I'm having a little bit of a crisis, sometimes it's already taken care of, and sometimes you can handle those over the phone. Most of the time you need to get in and assess the environment or need to get the person out of the home and into safety. That was about the cut of what we ended up providing. Please advance the slide.

And I apologize for the tiny print. These were some outcomes from our final year. Is I'll just draw your attention to the very far left. Those are prevented psychiatric hospitalizations and Bob had a similar outcome and services that we had been providing that Meridian had been providing in 2019.

But that's just the types of outcomes where you're preventing hospitalization, preventing incarceration. Other large bar kind of towards the right middle, that's prevented aggression towards caregivers. That includes mom and dad, DSPs in a group home or supportive living setting. These are the types of outcomes that are really thinking. We had a really -- Meridian services and Benchmark worked closely together to develop how outcomes were measured and these were robust outcomes that we were achieving. Please advance the slide.

So in summary, we -- we can prevent arrests. We can prevent hospitalizations and really help people attain terrific outcomes that they otherwise wouldn't do if there wasn't a specialist service. Very hard for a non-specialist service to achieve this

with this very tough, the challenges presented in crisis services. Please advance the slide.

That's it. Questions?

I'm not sure how we want to handle it. Maybe all three of us?

>>SPEAKER: Yes. What we'll do, and thank you, Doug, Bob, and Jim for your presentations. Board members, if you have any questions, Doug, Bob, or Jim, just unmute yourself. Come on, identify who you are, and then go ahead and ask your question, and we'll take as much time to questions as we need to. Board members, anyone with a question?

>>JOHN BARTH: This is John Barth, I have a quick question. I didn't understand the eligibility of the program when it was running. Was it for anyone Medicaid eligible or anyone in a waiver service. How is an individual eligible for services?

>>SPEAKER: I'll field that easily. That was a piece of our contract, very specifically, we would do presentative eligible. So even if a person -- if a person is already in the BDDS system we pretty much know they're going to be eligible for crisis support. But if somebody called in and maybe had moved from out-of-state or maybe hadn't accessed services, we would do presumptive eligibility which included specific questions like were you ever in special Ed or the client your discussing ever in special Ed. It was a low bar. If somebody was eligible, we

would provide support and with DDSs we would determine, BDDS took the reins from there H it was pretty much anybody in Indiana and you didn't have to have a Medicaid recipient.

>>SPEAKER: Any additional questions?

>>BOB COLES: This is Bob. Can you hear me?

>>SPEAKER: Yes.

>>BOB COLES: Yeah. Okay yeah. I just wanted to add to what Jim said with that question. It worked the same way for Meridian. Back in we were in the crisis it was available for any person that had intellectual disabilities. They didn't have to have mental illness or even a dual diagnosis. It was available for anyone that was intellectually disabled.

>>SPEAKER: Any additional questions for board members? Well thank you Doug, and Bob, and Jim. We appreciate you're sharing that information with us, and with that, we will move on to our next items on our agenda, which is our Covid-19 update. And we will handle that the same way. We will have our presenters present, and then we will take questions at the end of their presentation.

So, our presenter today, we have a update on Covid-19 response, by Kylee Hope and in our update which is survey results and impact by John Barth and Arc of Indiana will be doing feedback from self-advocates and families. With that, Kylee, thank you,

and thank you to you and your team and all your efforts in making today a reality.

>>KYLEE HOPE: Good afternoon everyone.

Thank you for being here, and again continuing to do this with the technology, as always, it's quite a event, an adventure if you will. Today I want to give you guys an update on the Covid-19 response that DDRS has been managing, along with many other stakeholder in this world and many other just personal. It definitely has a change of life, if you will, in March of 2020. I just want to kind of go through how we have addressed this and also provide you with respect to some data as we have seen it. Want to go to the next slide Tom?

So, as we reflect back on our past several weeks we thought it would be helpful to review the path we started with the 1102 task force, and where we find ourselves today. As you may recall in March we began operating under the governor's emergency executive order declaring public health emergency due to Covid-19. On you response is pretty simple. We started running. We all started running, we were running to get necessary protections in place. Running to make sure we had adjustments and making sure there were preparations to operate in a direct response with respect to the pandemic. While I know most of us weren't literally running, the feeling to need to operate with an immediate sense of urgency or good amount of

time can feel much like a sprint that goes on for a little longer than any of us, me personally, can even actually sustain. So, next slide.

As DDRS started our respective, if you will, sprinting, we were -- faced to clear a path for immediate support needs for individuals within our services. We identified and requested as quickly and in a number of cases, with a little ability to plan specific code waivers that would help facilitate service delivery and supporting people in very non-traditional ways. We were able to begin to vault tools and operationalize flexibilities that we could implement in a variety of ways and modalities and one in particular was appendix pay mechanism of our waivers to facilitate service delivery in alternative or different ways through our homing community-based waiver. In introducing these more immediate changes, we needed to quickly move to provide additional policy guidance and resources and information to stakeholders to manage. Also while managing the pandemic in less than ideal circumstances. We had our own staffing challenges, provider staffing, direct care needs, that we knew going into this was a long-term kind of initiative. We wanted to address prior to Covid, and not to mention kind of a continued resource need for our providers and direct care staff, specifically related to PPE.

Next slide.

So, as we entered into April, if you will, there was, for us, at least, an adjustment period, an acknowledgement and awareness of a new work approach to our efforts in programs and administration in this pandemic. In March, of course it was a quick sprint in getting things out is operationalizing as quickly as possible. April we were kind of able to take a breath and develop a cadence to our information sharing and connecting with stakeholder is to the best of our ability we moved toward a modified system of service delivery is altered the purpose on the full impact of the pandemic, and long-term implications that may be arising. Next slide.

So as part of this adjustment period, we also recognized as a state that it was important that we identified or put forth a set of goals for our system, that we needed to utilize during this health emergency we thought it was important for DDRS and stakeholders to understand what the state was trying to accomplish. That maybe somewhat nuanced and different than what we were preCovid. So we also believe that these particular goals were -- helped establish the why behind some of the changes we were making. So again, you can read it, but really it's to -- our first goal was to help prevent the spread of Covid-19 and absolutely keep people alive. Right? I know many of you have heard me talk, in our team leaders and DDRS staff, talk about this always balance between health and safety and

what people are wanting to do in their life and how that intersection is with the service delivery model. We went into a mode of protection, and health and safety become a primary concern when you are managing in a pandemic.

The OP, we really wanted to make sure we could operationalize flexibility as quickly as possible. That was also critical that we were providing necessary communication, and making the necessary flexibility so people could still receive services as appropriate.

And we also knew, and it's appreciated the kind of provider network. We know they're critical to obviously our service delivery systems and we needed to ensure is maintain that network. Last we can't forget that we need to continue making any decisions for individuals that we support, and empowering those persons under decision making we try to avoid making any type of blanket decisions or blanket restrictions because it really is person centered just like all of us that may have fall into certain categories or high risk categories, impacted more by Covid, we needed to make sure that, while many of our individuals may be in those high risk categories, many of our individuals may not be and we wanted to make sure that person centered decisions were employed and to ensure those services were most appropriate.

So, again, as part of the adjustment, if you will, in April, to the DDRS communication efforts we absolutely had to title and we were trying to -- that are represented hereof what our approach, if you will, has been in the weeks following this pandemic declaration.

You know, as we continue to mover forward into the next phases of this pandemic, we will continue to largely rely on these same strategies to share guidance, to gather feedback from stakeholders of what is working. What we will also make additional adjustments and clarification and also rely on the feedback communication loop to further inform our communication and opportunities for sharing information directly from us to improve consistency and understanding. So as you can see at the top there, just as a FYI regarding kind of the start in to the March and April, we had daily FSSA leadership calls during Covid-19 we had DDRS leadership calls. We held a critical stakeholder group call on Monday, Wednesday, and Fridays as well as weekly IS DHFS SA calls what that enabled us to do is quickly respond to communication needs or any of identification of what wasn't working or what was working or what were some of the rough spots in making sure that we were able to get back to the appropriate people to make should quick decision.

The next slides, I am going to talk about, are just quick snapshots of some of the bureau program responses to Covid-19.

First up we're going to talk about the bureau of rehabilitation services. As part of their process, we were able to really remote deliver location rehabilitation services remotely, and we did do some continued in-person meetings, depending on access, but we continue to move forward of reopening those offices both the VRNB office was as we confirm all of our necessary needs for materials and protective equipment as well as Plexiglass needs moving forward. But we continue doing all of our specific functionality and remote format.

We also, go back one slide Tom.

We also are -- I'm sorry. I'm confusing you. Go back to the VR slide thank you. Reaching out to all employees, VR participants, we also feel like it's important that we were VR was able to really identify what are the Pacific needs of any open cases currently within VR. So we, VR is doing currently a reach out process to get the current employment status to identify which individuals and what our VR participants needs in terms of employment in recognizing that need may have shifted in light of Covid. So what are some of the supports they need? Do they need assistance had finishing PPE, are there adjustments to changes in job task or changes to their environment and how can we potentially support them in any virtual work they are doing.

We also, other objectives are really to get a statewide picture of the overall impact on employment of any identified

individuals that have been laid off or furloughed. So that we can get a better sentence specifically for the VR program. It may not be a whole snapshot of impact for individuals across the state that have disabilities but this will give a snapshot of that information related to those that are currently receiving services or have an open case with VR. And, again, we continue, there is guidance on the VR's Web site regarding Covid-19. A remote employment services that was issued in March. Again, remote employment service outlines examples of really meaningful activities that can still be carried out by providers, for new VR referrals during the discovery process or during job development or even after placement, which includes employment support like supportive employment. So we continue to make sure that we have identified ways in which even through a remote environment, we can continue providing those much needed VR services as well as VR is attempting to get a better snapshot of direct impacts that Covid-19 has on individuals in VR.

With respect to some VR specific data, we did and I see a trend with VR applicants as compared to the previous March through May. In 2019 we had about a 25 percent lower VR applicants. As a reminder, 85 percent of eligible individuals continue to be priority receiving services. We are seeing 85 percent eligible meeting the Pacific prioritization categories. We continue as part of our outreach because we understand with numbers, with

respect to the numbers we wanted to make sure people know we're still providing services is we're able to really help them. So really trying to communicate a message, what VR services are still available, so we sent a letter to all participants, with giving them ideas that we're still here, we can help you. Really making sure that, you know, do you need help finding availability employment opportunities during this Covid pandemic. Are you looking for different or future employment because there is some preparation or job development we can work on. And really trying to get a sense from them, if you're employer has asked you to work from home or if you are working from home, are you needing some other types of support to make sure you're successful in maintaining your job in performing those job duties?

So the first -- the Indiana search set program quickly developed is implemented new policies and guidance around virtual early intervention services. This included policy guidance on video conferencing, and telephone calls with families. Personnel and therapists and very much appreciated, they rapidly adjusted and are working on coaching families through those educations and therapeutic individual intervention to meet the family service plans outcomes and goals. You can see the service delivery policy changes on the Web site with respect to personal development. First step personnel would know they needed

support as they navigate the new service delivery model in order to assist, first steps develop best practice guidance document for developing early intervention. We developed a resource guide for all stakeholders. We were able to work with I. DC to create some tip sheets. How do you talk to somebody did tele-intervention, what does this electric like from a remote perspective and implementing services. We also held multiple Webinars in training with I. DC in how are you supporting the implementation of tele-intervention, and we tried to celebrate personnel and honor those nominated, absolutely in the 2020 excellence awards on Friday June 12th. Unfortunately this year we had to cancel our first steps early intervention conference but we were still able to identify and provide an excellence of service award to those individuals who truly deserve that award. Communication with stakeholders, first step team had provide the technical assistance and support for all of the system's point of entry. They had provider agencies is independent providers. They held weekly calls to make sure they were able to again continue to have that feedback on communication and what was needed.

With respect to getting back on track, first steps was deemed an essential service by the governor's office in March. So face-to-face services have been permitted throughout Indiana shelter in place stay-at-home order however we recognize that

many individuals did not do face-to-face meetings for a whole host of reasons however it was a priority as well to make sure that we had guidance for stakeholders currently in June now, as it is appropriate, how do you continue to host face-to-face visits to ensure that families continue to have access to their services as well as whatever makes the most sense that they can continue to meet their goals with the service plan. And those particular documents and ability to identify how to do those appropriate in-home visits or face-to-face visits are on our Web site as well. With respect to the next slide, this is just a brief, a quick snapshot of data showing a comparison from May of 2019 to May of 2020 and the potential impact that Covid-19 had on first steps. As you can see, there, we had a degrees number of referrals, evaluations, new IFSPs, there definitely was an impact with respect to early intervention is specifically Covid-19, however I want to just indicate that we continue to remain committed in selecting kind of this, not only this particular data, but also tracking a variety of data points and analyzing what are the impacts of Covid-19 pandemics. You know, part of that also was we anticipated that the shelter in place order would actually have addressed impact, because the number of physician offices open for well checks was somewhat limited, the number of families cancelling their appointments was also impacted and the number of families addressing their concerns

with development may actually have been put on the back burner a little bit due to life stressors they were experiencing. We continue to find ways that stakeholders, families, referral points, recognize that we're still open, we're still taking referrals and we are, maybe in some ways delivering services a little differently but we want to continue on moving forward. I want to say, I know it is June 18th that while our information, while our data is still not where it was last year, we have even over the past two weeks that these numbers have tended to steadily increased. That's positive. As the stay-at-home order and enter new stages of that, I think we'll continue to see an uptick in our referrals in order to ensure we're appropriately serving all individuals that may need early intervention services in Indiana.

So next, with respect to the bureau of developmental disability services and the bureau of quality improvement services, I want to quickly indicate that we identified and went through, to operationalize a variety of flexibilities with respect to Indiana code waivers and appendix A. We also had Bs and BQIS had accessibility with program administration. We attempted to do Facebook live updates. We did a family and video series in coordination with the Arc of Indiana and family voices to try to give them information and practical tips and tricks on how to manage in this pandemic. We also had weekly calls with case

management providers, providers weekly Webinars with providers and case managers specifically with each residential provider to ensure that we were getting necessary information, and they were able to provide us with additional information as needed. Again, part of that communication with those providers, directly, we were also able to communicate any particular understanding that there were site closures, so if adult day sites were closed we were able to gather that information more quickly we could understand if there were Pacific visitor restrictions and what was of the change of service delivery and in the current time who is opening, what is opening and in what capacity and what terms. We also utilized our partnership with the culture of quality with to continue to brainstorm how we utilize Covid-19 data and the tracking effort and manage this currently. And even in the future if we have to operationalize this again for any particular spike or surge in any type of Covid-19 issue, we also continue to have written guidance and communication on our Web site and continue to track the following data as well. Just want to do a quick -- to be fair, a shout out to these management teams, specifically the stint director is John van wick and Shelly Thomas who help in the day-to-day. They were asked to present in a national conference on our developmental work and collecting data and responding specifically to those particular needs. Next slide.

This also gives a quick snapshot of where we are tracking for the application data. Make sure -- the next slide, Tom.
Sorry. Maybe I went too fast. One more.
One more slide.

>>SPEAKER: Give me just a second. I have lost my -- [indiscernible].

>>SPEAKER: Okay.

>>SPEAKER: Thanks Tom. This gives us a snapshot of the application data where we are tracking. We're projected having for right now, 2020 we're currently at 2,800 applications. This is clearly the low where we were tracking in the previous year. We, again, similar to first steps, will anticipate applications likely going up as the stay-at-home order and stages of Indiana likely continue to reopen.
So, wanted to give you, again, an update of where woe are, so specifically track infinite reports of any specific Covid-19 positive cases and as well as any deaths related to Covid-19. As, again, we serve approximately in both the home and community-based settings of both waivers as well as any institutional settings, we serve approximately 30,000 individuals in the individuals of development disabilities services this is data as of group 16th. Current case counts from beginning of tracking in March we had 206 positive cases of Covid-19, is we have had, unfortunately, 12 Covid-19 related

deaths. This chart provides you a snapshot of where those Covid positive cases were individuals, what they -- so 108 of those individuals received the CIH waiver, 65 are residing in a supportive living site, and 33 of those positive cases were family support waiver. With respect to Covid-19 related deaths, we had 12 that were in supportive group living is seven that received a CIH waiver and one that received the family support waiver.

Next slide.

This is just to give you a nap shot of where are those cases actually in Indiana. We have 27 specifically -- 27 counties impacted with like Marion St. Joseph and Tippacanoe are the counties that reported more than ten Covid positive cases.

Next graph, just gives you a sense of how those Covid positive cases, what the age break down was for in the system of individuals that have that. As you can see, the 18 to 29-year-old category actually had the most cases, followed closely by the age range of 50 to 59, and 60 to 69.

The next slide, again, is another way to look at some of the data. So looking at it from a reporting on a day by day, this is how many from our first count in March. What was it? March 5th. You can see where the spikes of the daily count as high as nine, we received. However, I am happy to report, as of the end of May, and carrying into here, June, we have only had

about zero to two reported incidents of Covid positive cases. This is a nice way we will continue to monitor the data to see if there are any specific spikes to that we ensure maybe if there is a small break out in a particular provider or group home or CIH waiver setting. So we are monitoring it that way as well.

This is also a quick snapshot of, with respect to -- is this the staffing one? Yes. As part of the Indiana state department health order to really ensure that direct care staff that are working in congregate settings are required to report to the state any positive cases of Covid-19 or death. So currently based on what has been reported to us, we have 186 staff that direct care staff that worked in congregate settings, were tested positive for Covid-19. Unfortunately we also had four deaths related to Covid-19. One of those deaths was work in a supportive group living setting, is three of those deaths were related to a CIH waiver, they worked in the CIH waiver residential setting. This is a snapshot of data. Sorry. Again, positive cases of the trend line of when those were reported. Again, those are going, you know, down, however, we do have a few spikes with respect to staff, and some of that is of timing when those are being reported.

So, this next slide, I want to give you a little bit of employment with respect to nursing facilities and these eligible

individuals that are residing in nursing. Of the current data from long-term stays versus short-term stay. This is long stay data we have 1,419 individuals living in nursing facilities. Nursing facilities also may have individuals designated as having an intellectual or developmental disabilities, but they have not been actually determined to be eligible. So sometimes there is discrepancy in the reporting from Indiana state Department of Health and DDRF with how we clarify IDD. I want to be clear that currently those eligible for services we have 1,419 individuals. So also, nursing facilities are not required to report incidents to the bureau of developmental disabilities related to Covid-19. We had our local office staff reach out to all of the facilities that we were aware that the 10419 individuals resided in, to really continue to gather information, and check to ensure what their status was, and what their needs are. And so also data, as I said before, does not include short-term stays with respect to the Covid-19 data. I do want to make one mention. I apologize, but this slide was not appropriately updated as you can see on the left, the scale is duplicated for some reason. But I do have the raw information here. So, as of, again, June 16th, out of the 1,419 individuals residing in long-term care facilities, we have 93 individuals were reported as having Covid-19. And total deaths we had are 15.

Again this demonstrates, this next slide demonstrates those particular counties in which the nursing facilities were, and where the positive cases were, as well as the deaths by county. So we are now already Midway through June, which seems a little crazy. But in May, we, again, started looking to the next stages of the back on track plan for Indiana a and we were at pint in this situation to identify the path of really kind of changing the force. We were able to release, luckily, service disability grants to offset funding. And we continue to look forward and identify way in which we need to reimage if you will some of our DDS services and ensuring that we're being responsive to individual needs, family needs and provider needs. Just a quick, I wanted to point out, that we definitely have learned a few things of dealing with this particular pandemic. And through the regular touch points we have had with providers during these web sessions is other discussions and through regular contact with case managers, families, and other partners we have been very much encouraged. I want to recognize here this a significant amount of stepping up happened in our field across the state every day. We have been simply amazed by the challenges DSPs and others have phase and continue to face in this work. And we have heard time and time again of how people work to overcome these daily barriers. I don't want us to lose the positive particularly for the individuals we support who

have in tough times been exceptionally resilient. Finding new outlet's of interest becoming comfortable with the new norm and some cases preferring the use of technology in receipt of the services. We need, we must carry these positive tributes forward and use these individual strengths to help build on what that new normal may look like. In saying that, I think we also recognize that there were some challenges. We continue to be challenge moving forward. We know there is uncertainty at level program across the state. We know in managing that uncertainty there is awareness of increasing staffing challenges that Covid-19 has now complicated and exacerbated to a large extent. We look to unwind and untie some of the system flexibilities that were put in place to manage the pandemic. So we continue to, you know, highlight the positives, but also recognize some of the challenges moving forward.

So, in looking forward, to where we are headed, here some of the questions we're currently evaluating. I challenge all of us to really reimagine the normal. That we need to build on the activity of that grit, and this has gotten us this far. How do we continue down a trajectory that highlights individual's true potentials and acknowledges some of the everyday barriers and feelings of isolation and put on individuals with disabilities even without a pandemic present. Part of moving forward and finding the balance, how might we actually listen better to

individuals with disabilities? How might we continue to acknowledge the importance of social connectivity today and tomorrow? How might we consider which habits of our system actually should just remain extinct and which new habits should remain and what is actually any of those light bulb moments from our system that we need to continue moving forward in? So lastly, I want to demonstrate that -- oh no, is the picture not showing up Tom? Oh there we go.

Anyways, there should be a slide deck that really was pictures that were gathered actually from several Indiana community providers. So thank you. But I continue to be in awe of on you our community has come together to support each of us, all of us, during these difficult times, and today's difficult times happened to be Covid-19 health pandemic. I have appreciated individuals with disabilities in their families who are supporting each other and finding creative ways to stay connected to their friends and families and community. I have appreciated providers and therapists who are working to ensure they're supporting individuals and families while keeping them healthy and safe. Direct support professionals who are the backbone of the programs we're working tirelessly to ensure individuals receive their necessary support. Case managers who are helping families and individuals navigate this New World so that everyone can continue on their positive trajectory for

their best life. Staff of the division of disability and rehabilitative services, really to be honest, kicking as and continuing to work to keep critical programs running. And local communities have truly recognized the need of individuals that we support every day and families who have offered a variety of supports and resources. And with that, I just want to simply say thank you. And to thank you to everyone who is listening who has impacted individuals is families. So thank you very much.

>>SUZANNE CROUCH, LT. GOV.: All right. Thank you. John, do you want to go ahead and present?

>>JOHN BARTH: Thank you, lieutenant governor. I appreciate it. Let me just start by saying I'm John Barth, I'm the president, CEO of the Indiana association of rehabilitation facility. I am going to give a broad overview of the impact of Covid-19 on the industry that serves people with intellectual and developmental disabilities. It's timely and helpful that I'm going right after Kylee, because I think one of the things that's going to -- that has ensured that we have been successful so far, in making it through the pandemic, has been a strong partnership between FSSA, rodly, and TDS specifically with INARF and with having us all present together consecutively, I think will really draw that out. Moving on to the next slide.

INARF. I'm going to give an overview of the impacts of the pandemic on the industry. Facility based and community activity shutdown, concurrent closure orders. So depending on the counties and the agency alignment, somewhere around the mid-March time table, we started to see closures of day service programs. On the employment side, for individuals, and individuals with IDD who were or are employed in the community, mostly work in industries that have been over-impacted by Covid, meaning there have been closures and restrictions, and you see that in manufacturing and service industry, especially.
Stay-at-home orders have had a material impact on people's lives. Individuals with IDD are home more often, in their own homes or with their family's homes and that drove up the need for residential staffing and as Kylee noted earlier, that's happening without adequate funding and in the face of an ongoing Existing DFP staffing shortage. The fact impact has been very material for individuals living with their families. Families now became responsible for support and intervention over time when the individual would -- or day services otherwise. That's impacting staff. And we talked about the DSP staffing shortage, but some day service staff who could have moved over to the residents do that during the pandemic.
So we can switch slides.

Now, I'm going to talk a little bit about the physical impact, and sort of teeing up the more detailed slides I have here in a minute. Let me give an overview of what the increased cost have been to the industry that serves people with IDD supply. So increased cleaning supplies and cost. PPE, cleaning supplies, hand sanitizer. I think it's worth noting and working with our membership had worked to do some bulk purchasing and to try to lessen the impact cost wise on PPE, and we learned not only supplies has diminished but the cost gone up. Based on demand and who is bidding on items across the country, those items could go up double, triple, quadruple in the course of a couple of days. Not only is the purchasing of new items that were not envisioned during budgeting, but those items varied widely in their cost and that curve was not going down. It was always going up. So that's an unexpected but big cost. On the operations side, there is increased cost for technology. So needing more tablets and laptops for folks to work from home to communicate remote he. Subscriptions for the kind of service that we're using today for this meeting to have remote meetings and remote interactivity with clients being
served. -- expenses, and policy development and Covid-19 training implementation. I think there is something we have all learned during the pandemic, and it is that, by definition our knowledge of Covid is never complete. It's always evolving and

we're learning new information about it on a daily basis, which is helpful, helpful for us to reopen, and helpful for everyone to keep themselves safe as they're interacting in their day-to-day lives, but it also means increased cost for ongoing training for staff to make sure that the best possible processes are in play.

Obviously there has been revenue lost, services that could not have been provided, and then on the administrative side, over time, our unemployment insurance cost, with new hire training and on-boarding as well. Go to the next slide.

Now we're going to get a little more granular on actual cost. We went ahead and put this in here so folks can see the real dollar impact of the pandemic on the agencies that serve people with IDD. But I want to just caution by saying these numbers are now six or maybe even seven weeks old. So these numbers have gone up since we did the survey.

Here in INARF we did a survey of our numbers and got three responses and this is what the responses told us. That our members had an average of 173 days of operating cash on hand. That the average available line the credit was just over a million dollars. That the average Covid-19 related expense, about $14,600 is that includes, in a month -- and that's all the things I noted earlier, PPE, cleaning agents, training hours et cetera the next one is actually the cost per month. Actual

revenue loss 100,000, you can see the costs are significant and the material average additional direct care staffing cost was 47, almost $48,000. And then average additional indirect staffing cost was about $9,200 a month.

Moving on to the next slide. Going to summarize some of the impacts and some of the items that we're tracking going forward. So, as noted, in the last couple of slides, the industry has had significant loss of revenue, both continuing to serve individuals and as Kylee noted, doing so in a really resilient and innovative way. Adding new technology, learning to do services from a distance, working hard to alter the facilities. We have to ensure that there is safety and social distancing and masks available.

All those adjustments and innovations have happened in an environment where to date we have not had much relief. We appreciate the state has stepped forward with relief, upcoming 4 months of relief focused on day services that will come via a monthly grant program that is now in flight. So that's good, on the day services side.

One of the challenges is that, on the residential side, there has not been relief for that portion of the industry or that service being provided, and residential providers have borne expense during this time as well. All of the items I mentioned earlier. Staffing, overtime, PPE, same issues, same cost, but

no ability to recoup those costs or ability to mitigate that to date. Kylee did a thorough job discussing the service delivery flexibility, and I think that's a great example of the partnership between FSSA and the industry, put forward the opportunity for changes in adjustments where services can be delivered is how services can be delivered.

I'm I think the thing that I mentioned consistently, and I'll stick with this example, has been using tele-services. That's been a big benefit, I think, to everyone, if you learn that there are opportunities to serve individuals remotely. And potentially that a version of services going forward, as a new approach for interacting with individuals is providing services during the pandemic and beyond.

Another concern, is anyone who watch the activity in the state house yesterday saw that the suggested tax revenues and real tax revenues are less than budgeted. That's caused the state to take the action of asking for budget reductions across all state agencies. That's a big concern for our industry. Obviously because what those budget reductions will look like, and how they will impact an industry already, significantly affected by the pandemic, with limited response on the fiscal relief side is a big concern. And that's especially true if you factor in that most of the programs and services provided by INARF members are 100 percent funded by the Medicaid program. And they're

ultimately between 10 and 12 percent of be Medicaid budget. So the current environment for the provider world, as it's been affected by the Covid pandemic, is a lot of concern about what the future looks like, and what the architecture, and support systems for individuals with IDD, and their families, would look like as we continue through the pandemic and ultimately on the other side of it. And then let me finish wrapping up by looking at the final slide.

The thing I want to mention is, I am new to the position. I have been president and CEO of INARF for six weeks, and the benefit I have had of starting in a pandemic, to the extent that you can start looking for silver linings, is I have had the opportunity to enter a lot of activity with our CEOs across the entire state. Very much like this, interacting remotely, interacting on video conference. But the thing that's been heartening to me, is every single interaction I have had with a CEO has started with, John, this is what we're doing to best server members, and to make the changes and innovation we need to do to make it through the pandemic and make sure individuals we serve are getting what they need. And some examples of that are on the slide. In the upper right Benchmark human services they started mask production, and at the bottom you see new Hope of Indiana a made a point of having a day of cares to show support and appreciation for the residents, clients, and staff,

and you have the left, you see ADEC, that's how you're seeing tele-services being done adding that component to therapy and employment services.

The industry is working hard, doing everything it can to serve individuals with IDD. We need to really focus on the fiscal side now and how we can make it through the pandemic to be as strong and as resilient and available for services as we were at the beginning of the pandemic. And I'll end it there.

>>SUZANNE CROUCH, LT. GOV.: Thank you John. With that, Kim from Arc, and after Kim, we'll take questions from the board. Thank you.

Kim, you will need to unmute your microphone, please.

>>SPEAKER: That always helps. Doesn't it. Good morning everybody. Good morning. It's good to be with everybody today. I, too, just want to say thank you to everybody who has helped us through the last couple of months it's certainly been an experience that has made us stronger and better despite the frustrations and anxiety it has caused. If you can go ahead and go to the Next slide, please.

I want to do a quick reminder of the Arc. We were started by families, we are governed by families, we're carrying out a mission to make sure the issues that are important in the lives of people with intellectual disabilities half of our services across the state, the concerns that John shared with you from a

provider perspective are certainly shared by us and we appreciate him pointing those out. I want to give a warm welcome to John in his new position as president and CEO of INARF. We consider INARF as a close partner, and I am happy they chose someone to support their organization who has a good mind and good heart who supports persons with developmental disability. And I look forward to working with John in his new capacity. Next slide.

We started in mid-March and early April, really, as I think Kylee talked about, was a sprint. So we had over 869 conversations with families, and that represented about 371 individuals. This information was prepared for our May 20th meeting so you can add about 200 conversations to the list. This does not include Facebook, contacts or e-mails, which we're certainly plentiful as well during that time. I will say that during the beginning Hoosier families were settled down as requested and families were trying to react to what was happening is trying to get their home lives in order. Especially those who had school age children where they were navigating not only the services, but also school and potentially working from home as well. So it was a difficult time. Self-advocates of Indiana continue to meet on a weekly basis. They had 13 specific phone calls during this time period of 154 self-advocates they continue to meet on a weekly basis so

those numbers are higher. Conversation we had with families over the course of this period of time remainder on a lot of different issues. Several it was first about how the Covid crisis was being handled at all levels, certainly talked a lot about specific issues. There was a lot of conversation specifically about the federal stimulus packages and the impact that would have on families, and self-advocates and then also just starting to talk about reopening procedures. Because we knew that as that was getting closer, it heightens anxiety for a lot of individuals. Next slide, please.

I'll focus on March and early April really families were responding to services in different ways, day services closing programs and doors. Remote access including meetings with case managers all of that was very overwhelming and it was difficult for those families to don't have technology readily available. Had a difficult time, if they couldn't see their loved ones who lived -- residential setting so it was difficult on all of our families. As the federal stimulus packages came available is were released a lot of families had questions about what does it really mean how is it going to impact them. A lot of people with disabilities had concern about the stimulus packages how they might affect services, access limit on benefits and we certainly spent a lot of time trying to navigate those systems. Next slide, please.

So then as we entered April, a lot of conversations turned to what services were going to look like in the future. I think once everybody got settled into the way things were, there was a lot of concern about, now that we're here, how much longer are we going to be here and what would be new normal be, we will be transitioning into a different way of doing things again. We have a lot of people within our community who do not take well to change. Don't take well to sudden change, and so a lot of behaviors were coming into play. So we were changing in early March, mid-March, we were changing again, in May, and then what was it going to look like when June started to open up. So again a lot of heightened anxiety. Mostly people with developmental disabilities, certainly through providers there was a lot of concern about what it would look like if they entered a hospital, would a familiar or caregiver be able to go with them to help them understand what was taking place, understand the care they were receiving when we had to rely on on a lot of partners. This indicated information was available. Again as things started moving forward and we knew that Indiana was a moving more towards stages of reopening there was a lot of concern about working with our providers to make sure reopening of services was as smooth as it could possibly be. Next slide, please.

In late April, again, as we knew that reopening was going to be drawing near, we worked closely with Kylee and her leadership to bring together a group of families and self-advocates to really start talking about what those reopening procedures would look like, and I'll pause here for a second. Kylee did a nice job during her precedence -- thanks to everybody in the community and their work and reaction to how quickly they reacted to the pandemic. I want to make sure Kylee and her team get a large thanks as well. Her team continues to be excellent on communication. Three times a week stakeholder meetings were very much needed, very much appreciated and helpful. We shared anxiety and concerns that many people across the industry were facing, sharing family self advocate perspectives and worked together to ease concerns. Kylee please know how much you're appreciated ask your team, specifically during the pandemic everybody stepped up and has gone above and beyond. It was nice to know we're not in this alone and that you shared our frustration and anxiety and again just want to make sure that we thank you appropriately. We had a dozen families get on a call with us. We had more than a dozen give feedback through e-mail and other means. Just to talk about what it would take for reopening and them to have a level of comfort and putting individuals back into services outside of the home.

That conversation centered around four issues. Health and safety foremost, people concerned about loved ones with compromised immune systems what that would mean and what risk they would be under in going back into services being around other people. Communication is -- can never be overemphasized. I think many of us think we communicate well, but I think all of us know we need to communicate better. And I being that was certainly learned during this process that we need to make sure that the communication is not just among us as stakeholders but also amongst providers, case manages and families. Families supported a tiered approach to reopening and also families felt very strong about all of the training that needed to be done both at the staff level and as well as training at the family and people with disabilities as well.

Next slide, please.

So to talk specifically about health and safety, again, families really wanted to have confidence that the providers were following appropriate procedures regarding cleaning and use of masks and social distancing. I think families were very much aware that not all people with disabilities were going to be comfortable wearing a mask. And they would have to work with providers to figure out what type of mask could work. Was a shield needed instead of a mask, and so they wanted to, again, make sure communication was strong, so that they, again, felt

good in what providers were doing. We also wanted to make sure that people who were living at home with family, that, again, those health and safety procedures took into mind and account the families who are living with those people. A lot of those families are older, they have compromised health issues as well so they wanted to also make sure they were safe in what was happening.

Next slide, please.

Again, just to reiterate communication a little bit more. I think communication is an area that families would say certainly could have been better during this time.

And I think, again, that's not a harsh criticism, or not meant to be a harsh criticism in about way. Because I think most families know that everybody was moving at a record pace in trying to get things set. I think all families would share is that it would be nice to know that conversations are taking place, decisions are being thought through even though a decision is not made yet. So at least be kept into the loop that everything is being discussed even though a decision is not being made and as soon as that decision is made, that will be shared wisely. Case managers was an another area that self-advocates want to continue and wanted to hear more from their case managers on a regular basis to know how services are being delivered, what reopening is going to look like, and again

making sure everybody on the team had a strong communication strategy.

Next slide, please.

A lot of people have talked about this tiered approach and what we mean by that is when reopening happens instead of allowing everybody to go in at once is to look at a tiered approach. Looking at individuals going back into services who, either lived, and any group home provider or other residential setting or provider where it was kind of known what all that I had been doing, who all they had been working with, to kind of just note of that again, health and safety is first and foremost. And individuals with serious health issues, compromised immune systems that those may be one of the last groups of people to go back into work. Just to make sure problems were resolved as reopening happens and that the transition was as safe and as smooth as possible for those people with the most significant health needs.

Again, the one area, as we were kind of talking about this can the tiered approach. We knew that there was going to be an overlap or some discrepancies between when a provider started reopening and the tiered model of who would start opening for services first and how that impacts families working from home being called back to work and what was going to happen when those did not coincide well together and when families were

called back to work before services reopened and so those were all things that we wanted to make sure the communication was strong between families and providers working through those issues. Next slide, please.

There was a lot of discussion about training and just wanting to make sure that everybody was on the same page as far as expectation, on cleaning, on hygiene, on the use of PPE. And families to make sure that they were doing their part to make sure that their loved ones were -- was as prepared as possible as going back into services, that the families were practicing the right health and safety procedures at home, that they would also be doing, within a provider setting, as well, and so, again, just wanting to make sure that those appropriate communications took place so everybody was, again, on the same page as far as training. We learned a lot during this process that a lot of our folks in Indiana, who have a disabilities went it see video and Webinars and hear from other advocates in the state of Indiana. They wanted to recognize the voice or picture, the face of people that they know in Indiana, and so self-advocates of Indiana worked hard to create videos and Webinars during this time to help people around our state understand the importance of washing their hands, the appropriate way to wash their hands. Importance of wearing a mask, how to appropriately wear a mask and where all that needed

to take place. We wanted to make sure Indiana was in the best possible information and getting the information out to families and people with disabilities. I want to turn it over to Shawn now to talk more specifically about the self-advocacy conversations he can do that better than I. But I would be happy to answer any questions when the time comes.

>>SPEAKER: Okay. Can you hear me?

>>SPEAKER: Yes. Shawn, we can hear you. Go ahead.

>>SHAWN FULTON: Okay. All the -- these next slides come from people with disabilities from all over Indiana. So self-advocates discussed a series of concerns throughout the Covid experience and also made suggestions to providers as they look to reopen.

Communication was a consistent concern described communication as for during the crisis and a strong need to improve communication going forward from case managers and providers.

Concerns about new health and safety procedures -- [indiscernible] they understand. Masks would be difficult for some people to wear due to allergies, anxiety, asthma, sensory issues, et cetera recommended having face shields as an option, social distancing will be difficult for in as they like to show sections and -- on --

We need to be aware of increased behavior due to anxiety, and -- [indiscernible] too much. Also new behaviors should be

expected in a change of routine, as people learn and get used to health -- [indiscernible]

Many of -- many may experience decline in social skills that have been learned and gained during -- [indiscernible]

[AUDIO DIFFICULTIES]

Self-advocates suggest using videos and Webinar to help prepare to transition back into services to help anxiety and decrease -- behaviors. Self-advocates have strong relationship with their direct support professionals, and are concerned when they -- change someone into -- providing their care. They are concerned about DSP, who are providing care of two people, who are Covid positive. There is a big concern about a lack of PPEs and will there be enough. Many expressed that they are ready to return to work service. They are going -- depressed and -- concerned due to isolation. There is a strong concern about availability and factor community jobs that were lost -- [indiscernible]

What they -- getting back jobs -- for those who lost them.

Thank you.

>>SPEAKER: Hi. Thank you all for joining. Lieutenant Governor Crouch had to jump off. She had another meeting. So, are there any questions for our three speakers, Kylee, John, or Kim, Shawn? Any board members who have questions?

All right. Hearing none, Kylee, I believe on our agenda, we have a quick update on the 1102 task force recommendations could you give us a quick update on those?

>>SPEAKER: Yes. In your packet, there are an update, as we traditionally have done for the recommendation of 1102 task force, being quite frank, there has not been tons of updates from the last meeting due to, of course, Covid-19. However, I will not go through them all due to time, but I will encourage all of you to please review them. As you noticed in the previous kind of templates that we provided, we have identified those recommendations that have been completed, or nearly complete, those that were launched and those that still need some work, if you will, of various priorities or legislative needs. However, you will see on any status report, that the bold text, is the most recent update of any of those. See continue to look at that, feel free to ask any questions. I think at our next update, we could ensure that we have sufficient time to really be allotted to kind of going through those recommendations, in light of this current pandemic and what that means for the 1102 report, is how we feed to kind of continue on moving forward with what those recommendations may look like, or how we need to prioritize pieces in the future. Any questions?

>>SPEAKER: Thank you Kylee. Appreciate that. And the Lieutenant Governor wants all of our board members to know that we're going to keep the task force recommendations on every agenda to make sure that we do address that there are the recommendations and that we want to continue working with you and others. I appreciate that. Thank you. It looks like for the rest of the agenda, there are business items for the next meeting. There are any questions? Any topics that you would like to bring up for the next meeting that we can address?

>>SPEAKER: This is Jason Meyer, can you hear me?

>>SPEAKER: Yes. Hi Jason.

>>SPEAKER: Hi. Jason Meyer with passengers, provider out of northeast Indiana. Thank you again for the updates and just want to comment on the Covid-19 updates. I think those are extremely helpful. They worked for me. I'm not going to speak for the group but if we could continue those at the next meeting, I appreciate how both John and Kim and their updates noted on reopening of date services and that will still be going on in the phased in approach I'm assuming with most folks and how that impacts people served as well as providers, I think this's important to continue as well as service delivery, just those discussions, and reviewing ways to do that. So those updates are extremely helpful.

>>SPEAKER: Thank you Jason.

>>SPEAKER: This is --

>>SPEAKER: Anyone else?

>>SPEAKER: Kim Dodson. Can you hear me okay?

>>SPEAKER: Yes, Kim.

>>SPEAKER: I, too, for the next meeting, I think we do need to look a little more in depth as to the recommendation status to see where we are on things. I think Jason is right, as we see reopening, really come into play over the next month or so, I think September will give us a really good snapshot of where the providers are, as far as fiscal situations, reacting to reopening, and what our needs are, so if we're thinking about or if you're wanting input as far as time for another meeting, I think September would be good. Just because by then, again, I think we'll have a lot of information from providers and families on those reopening procedures.

>>SPEAKER: Thank you Kim. And I believe I had a representative clear, is that correct?

>>SPEAKER: Yes. Thank you Taylor, can you hear me?

>>SPEAKER: Of course. Well, I would echo what Kim just said, we should definitely meet in September, if not sooner, and I Hope we'll be able to meet in person, and I appreciate all the updates and the work that everyone has been doing and all of the presenters, I think it's critical to keep all of the task force recommendations on the agenda for every meeting, and I also

think it's critical that we have a fiscal discussion around those recommendations, because I think we knew been the pandemic, that many of those items were going to be a heavy lift, force recommendations were going to be a heavy lift, and now we're in a fiscal situation and -- lose momentum on services, the fiscal challenges are unprecedented and are going to be great, but these priorities, these recommendations deserve as much attention as anything else in the state government, and I think we need to continue to rally around them, and find ways to keep things moving forward and find the money where we can, to advance these priorities.

>>SPEAKER: Thank you representative Clere. Any other board members who would like to throw their thoughts out there on what our items for the next meeting would be?
All right. And you can always feel free to e-mail Kylee or myself, if you have further items that you think about before we schedule our neck meeting. I did make note for the Lieutenant Governor in regards to the suggestion, and also the September suggestion, so I will discuss these with her today after she's out of all of her meetings. I do know she would like to meet in person as well, during these unprecedented times, so we are hopeful we can maybe meet in person next time. But we do appreciate Kylee and her team if you putting the system together. I think it really worked well this time, and we

really appreciate it. So if I have a motion for adjournment, I will take that, and we'll go on our way.

>>SPEAKER: This is Kim, I motion to adjourn.

>>SPEAKER: Thanks Kim. Do I have a second?

>>SPEAKER: Second.

>>SPEAKER: Great. Everybody who agrees say aye.

>>SPEAKER: Aye.

[Laughter]

>>SPEAKER: Sound great. And I Hope you all have a wonderful day and I'll review the notes and make sure we have dates and times for our next meeting.

>>SPEAKER: Thank you.